Integrated Care System
Shropshire, Telford and Wrekin

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Shropshire, Telford and Wrekin

Mental Health Inpatient Quality Transformation Programme

1 Year On Update

Introduction

This update aims to provide you with the background to the 3-year NHS England led Inpatient Quality Transformation Programme (IQTP) which commenced in 2024. It will give a summary of the programme and then go on to describe the achievements and successes realised in the first 12 months as mapped against the objectives originally set out in the Shropshire Telford and Wrekin (STW) Integrated Care Board's (ICB) published strategy .

The update will also give an account of where we know we need to do more work, or make further improvements, and set out the key priorities for the programme for the next 12 months. These priorities will be set against the original strategic objectives and any new priorities derived from learning during the first year.

In July 2023, NHS England (NHSE) published its Commissioning Framework for Mental Health Inpatient Services which set out the core aims of the programme, namely that in relation to inpatient care, Integrated Care Systems (ICS) should focus on:

"…improving population health and healthcare and tackling inequalities in outcomes, experience, and access for all".

A key deliverable as part of these aims that needed to be reflected in local strategy was to set out:

- "…how they [ICS] will cease the practice of sending people to inpatient services at distance from their home and/or to outdated or risky models of provision. This includes (sic) to both acute and rehabilitation inpatient services".

Introduction

As such and working closely with our partners NHS Shropshire, Telford & Wrekin developed a strategy that set out a journey to deliver transformation that would ensure:

- Care was personalised.
- Admission was timely and purposeful.
- Hospital stays were therapeutic.
- Discharge was timely and effective.
- Care was joined up across our health and care system.
- Services actively identify and address health inequalities.
- An acute inpatient mental health workforce fit for the future.
- Continuous improvement of the inpatient pathway.

Introduction

To deliver on the 7 ambitions for the overall transformation programme set out above, the focus of the groundwork in Year 1 was to:

"Conduct a comprehensive analysis of the current state of adult mental health inpatient services to inform a strategic plan for transformation".

Delivering this groundwork is linked to **6 core actions**:

1. **Public engagement**
2. **Patient and staff surveys**
3. **Health inequalities analysis**
4. **Bed modelling and scenario planning**
5. **Workforce gap analysis**
6. **Commence Culture of Care interventions**

The PowerPoint presentation will take you through the journey of the STW ICS in the first 12 months, showcasing the achievements to date and setting out the work still to be done, not only to complete any outstanding actions from Year 1 of the programme but also to deliver the original (and newly developed) priorities for Year 2.

Commissioners' Reflections on Partnership Working

- Shropshire and Telford & Wrekin Local Authority specialist commissioners for adult social are actively engaged in the steering group as well as the rehab subgroup.

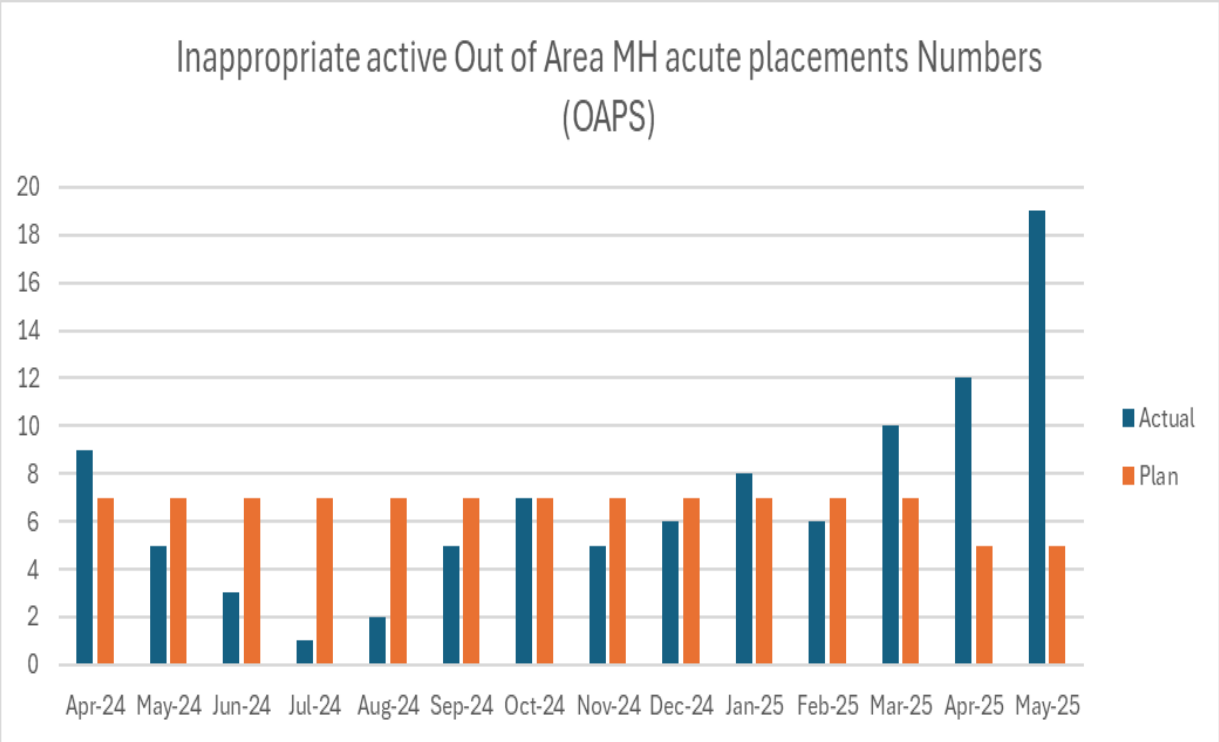
- We are pleased to see increased pace in recent weeks & are supportive of the approach being taken with LD&A.

- Our commissioners have informed the metrics that are in use for this programme. We are keen to explore these metrics and have a particular interest in outcomes and readmission rates.

- As provider of the AMHP (Approved Mental Health Professionals) service and adult social care in Telford & Wrekin we are keen to be part of the workstream focused on the acute offer to ensure admissions are meaningful and improve outcomes.

- Inpatient Mental Health Advocates (IMHAs) are now part of the steering group. IMHAs play a vital role in representing and advocating for individuals detained under the Mental Health Act, ensuring their voices are heard and that care is delivered in the least restrictive way possible.

Recent Performance & New Metrics Introduced



24/25 plan to have 7 max number of patients placed out of area (inappropriate only. This is where patients are sent out of area because no bed is available for them locally), performance improved through the summer months in 2024 but subsequently increased during Autumn, and have since remained high, increasing even further (to 19) in May 2025.

- Currently data quality exercise underway in order to measure performance accurately and see the impact of actions to reduce out of area placements.
- We have disproportionately more people placed out of area in Psychiatric Intensive Care Unit beds as there are currently no local female PICU beds, the closest male PICU beds being in Stafford.
- New metrics and dashboard going forward:
- Number of repatriations (a patient returning to the Area from which they were referred for treatment) Distance from Redwoods, as the nearest available inpatient service.
- Care formulation within 72 hrs of admission.
- Average Length of Stay (overall from date of admission of spell).
- Longest Length of Stay.
- Referrals for Out of Area beds for which admission avoided.
- Quality Patient Experience - post discharge rated.
- Patients with a co-produced recovery plan.

Year 1 - Achievements

NHS Shropshire, Telford and Wrekin

Year 1 goal: To conduct a comprehensive analysis of the current state of adult mental health inpatient services to inform a strategic plan for transformation

Health Inequalities Analysis

- Development of a Health Inequalities Dashboard which helps to provide insights to drive improvements to tackle health inequalities.
- Analysed data to identify and understand existing inequalities in access to and quality of inpatient services for different population groups.
- Health Inequalities Legal Duty Report developed to address these inequalities and ensure equitable access to high-quality care offered.

Bed Modelling and Scenario Planning

- Creation of a Demand and Capacity model - understanding options for embedding the outputs from the demand and capacity modelling through utilisation of the bed modelling operational tool. This model also supports the management of risk in terms of meeting patient outcomes and best value whilst supporting decisions around planning of service provision to provide the right interventions and reduce inappropriate out of area placements.
- Development of a 'User Guide' which provides high level information on the functionality of the demand and capacity model, so that Trust colleagues can use the model going forward to assist with operational planning.
- Development of a 'Data Book' which provides the detailed data specifications used as the model's foundation.

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Population Health & Business Analytics Example

Year 1 - Achievements

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Year 1 goal: To conduct a comprehensive analysis of the current state of adult mental health inpatient services to inform a strategic plan for transformation

Workforce Gap Analysis

- Underwent an Establishment Review to ensure safe and effective patient care is provided.
- Analysed current staffing levels across all disciplines and compared them to projected needs based on bed modelling and service transformation plans.
- Identified existing workforce gaps and have developed strategies to address these which included recruitment, training, and retention initiatives.

Commence Culture of Care interventions

- Partnered with the national Culture of Care programme to identify and implement interventions for staff, this focused upon building compassion, communication skills, and de-escalation techniques.
- Numerous Inpatient improvements have been evidenced during Year 1. Improvements and activities for Year 1 are shared below, with intentions for Year 2 identified.

Year 1 - Achievements

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Year 1 Goal: To conduct a comprehensive analysis of the current state of adult mental health inpatient services to inform a strategic plan for transformation

- ✓ **Patient and staff survey reports** with action plans for improvement
- ✓ **Health inequalities analysis report** with targeted strategies for addressing inequities
- ✓ **Bed modelling operational tool -** Options for the embedding of outputs from the demand and capacity modelling accessible to relevant Care Group staff
- ✓ **Workforce gap analysis report** with strategies to address identified gaps
- ✓ **Audit Action plan** is in place with key focus areas to prioritise
- ✓ **Progress report** on the implementation of Culture of Care interventions
- ✓ **Evaluation plan** in place, understanding our baseline position

Ongoing Objectives from Year 1 to be Completed

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Year 1 goal: To conduct a comprehensive analysis of the current state of adult mental health inpatient services to inform a strategic plan for transformation

Public Engagement

- Conduct focus groups and surveys with service users, families, and carers to gather feedback on experiences, needs, and priorities.
- Public engagement sessions to raise awareness of the programme and gather community input are being held during **August to October 2025** (delayed due to specific restrictions on communication activity prior to the General Election 2024 - this prevented full engagement as planned).

Patient and Staff Surveys and Culture of Care

- Develop and distribute surveys to patients and staff to assess and identify areas for improvement, and capture workforce needs.
- Analyse survey data to identify trends and develop action plans based on the findings.
- A Train-the-Trainer programme to ensure long-term sustainability of Culture of Care principles within the workforce to be initiated.

Further Learning from Year 1

Culture of Care

- Working towards addressing the 12 key principles (as shown in slide 35 below) further learning is continually taking place as each respective principle is reviewed. For example, the many changes that have taken place already within Year 1 involves the process of identifying, developing, implementing and evaluating the changes and new introductions within the ward settings.
- This is testament to the ongoing collaborative working taking place between staff, patients and family/carers. This cycle of continual learning and development is essential to ensure the best outcomes are provided to all our patients. All of the Quality Improvement ward work taking place considers all 12 standards whilst continuing to align and utilise the principles of Trauma Informed Care, Autism Informed Care and Anti-Racism.

Purpose of Admission

- Weekly discharge huddles with Holly, Birch and Laurel ward, are now in place. Currently working to spread this to the remaining wards.
- Work is ongoing around the Purpose of Admission protocol to set out a clear plan of full implementation. Additional work is underway to identify resources needed to support early discharge from the hospital ward through huddles, discharge meetings etc.

Recruitment

Some of the new roles that have been introduced which will directly/indirectly support the Inpatient Quality Transformation Programme are:

- Deputy Director of Lived Experience – Appointed as permanent post
- Associate Director of Lived Experience – Appointed as permanent post.
- Patient Flow Manager – Appointed as permanent post.

Further roles within Lived Experience, Family Liaison, Co-Production and Peer Support are being developed.

Further Learning from Year 1

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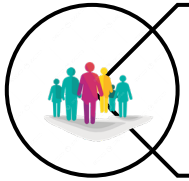
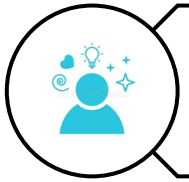
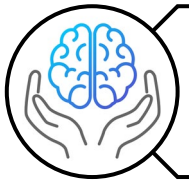
Rehab learning



Community mental health rehabilitation is a core element in a whole pathway that supports people with severe mental illness to recover and live well, as equal citizens in their community.



The healthcare element of rehabilitation is one component of the pathway; good community mental health rehabilitation also requires a place to live, something to do and social networks.



Local community rehabilitation services has enabled people with complex psychosis or other severe mental illness to live close to home and in the least restricted way, to be supported to manage their symptoms in a way that promotes their autonomy and to recover as defined by them.

All elements of the mental health rehabilitation pathway, including tertiary community rehabilitation – that is, local rehabilitation that is essential and cannot reasonably be done in universal, primary and core secondary services – should be delivered in a way that meets local population needs and makes sense for the system.

This will require strong collaboration within localities across a range of partners, including health and social care, housing and support providers and local services for specific issues such as substance misuse.

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Forward View Year 2 2025 – 2026

Commitments

- Develop a detailed service transformation plan informed by the Year 1 analysis and stakeholder engagement.
- Implement service redesign initiatives based on the chosen model (for example, establishing specialised units, creating new pathways for admission and discharge).
- Continue rolling out Culture of Care interventions and expand the programme to all staff.
- Address identified workforce gaps through targeted recruitment, training, and development programmes.
- Monitor and evaluate the impact of service transformation on key performance indicators such as patient outcomes, length of stay, and staff satisfaction.
- Analyse data from Year 1 to inform targeted interventions to address specific patient populations and service needs.
- Bed modelling trajectory to evidence impact of bed modelling interventions in year 1, to understand the effect of bed growth and requirements for additional in area beds.

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Progress and Next Steps

Acute Care

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Localising and Realigning Care – Acute Care

Achievements and Progress to Date

- Full review of patient flow, processes and pathways ongoing.
- Bed Flow Manager commenced in role April 2025. Bed Strategy flow improvement for purposeful admission being reviewed.
- Proceeding with Bed modelling and Bed-based review to understand impact and associated actions.
- Cross referencing direct progress being made by Autism and Learning Disability Liaison professionals and Inpatient staff with the high-level milestones.
- Reducing reliance on in-patient care by clinically reviewing all requests for admissions.
- Through Culture of Care, we are continually spreading learning across all wards.
- Proactive discharge planning and proactive effective support through structured huddles and reviews and partnership with community services.
- Proactively recruiting to vacancies and seeking to support existing workforce to create a positive working environment.

Next Steps

- Continue to undertaken interventions to reduce demand for existing bed provision ensuring impacts of interventions are measured for impact. Ensure interventions incorporate required reasonable adjustments.
- Exploration of capital investment opportunities to enable local PICU bed capacity where this is clinically indicated, and to further reduce need for out of area admissions.
- Explore partnerships with Voluntary, Community and Social Enterprise (VCSE) organisations, Housing organisations, and independent providers. This is based on the recommendations from Bed Modelling report.
- To create a more accessible, efficient, and recovery-oriented system, by focusing upon discharge planning and community support, preventing avoidable admissions and readmissions.
- Develop further alternatives to inpatient care.
- Improving patient outcomes through further development of the therapeutic environment in respect of different patient groups.
- Reducing length of stay through more purposeful admissions, improving the therapeutic environment and development of stronger links with community services.

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Patient Flow and Reducing Restrictive Practice

Patient Flow

- Patient Flow Lead commenced in role April 2025.
- Currently reviewing processes with the emphasis on clinical input, looking at systems/processes within bed management and how this flows within acute care.
- Helps support and reduce out of area admissions by focussing upon building better working relationships with out of area providers of acute/PICU care (Psychiatric Intensive Care Unit).
- Repatriation of patients to be facilitated within a timely manner, with the least restrictive influence on our patients.
- Future improvement around communication between discharge Co-Ordinator's and ward staff to ensure alignment of working when planning for discharge.
- Identification of barriers such as improving communication between teams and developing clearer processes. Streamlining out of area bed allocation and having more oversight where patients are placed and keeping up to date with their journey.

Reducing Restrictive Practice

- MPFT's Patient Flow Lead has an active role in making clinical decisions around restrictive practice within bed management, ensuring every admission is planned effectively, fair, purposeful and in the best interest of patient and their families/carers.
- Improving working relationships within out of area providers to help reduce length of stay and support the patient journey.
- The Patient Flow Lead supports the purpose of admission work internally and help to develop better working relationships with supporting teams within the community.
- Actively working with two Crisis Teams to ensure every admission is required, purposeful and to set expected discharge dates to ensure admissions continue to be timely and purposeful.

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Patient Flow Lead

"The impact of my role to date I feel has been a positive one, with changes made to how we repatriate back to home/Redwoods, which ultimately has an impact on the patient journey.

Small changes are being made to how we manage beds and daily requests that come into the service, such as a more structured approach to the bed management meetings.

I am working with Lead clinicians to enable better oversight and assurance when considering using Psychiatric Intensive Care Unit/Acute Out of Area units. Relationships are already improving with Out of Area providers, resulting in repatriation in a timelier manner and barriers to discharge being identified earlier".

Designing a Model to support Patient Flow

Helping Patients Leave Hospital Safely and On Time

Clear Plan from Day One
When a patient is admitted, we set a clear plan for their stay and use the *Red to Green* system — this helps us spot and remove delays.

- **Red days** mean nothing is happening to move the patient closer to going home.
- **Green days** mean progress is being made.

Discharge Dates with Purpose
We give each patient an expected date to go home, based on their needs, to help us manage care and plan ahead.

Patients Grouped by Stage of Care
Patients are supported in different stages:

- Being assessed
- Receiving treatment
- Experiencing delays

Each stage has clear actions to help things move smoothly.

Daily Team Check-ins
Our healthcare teams meet every day to review patient progress and update discharge plans.

Fixing Delays Quickly
If there are any problems stopping a patient from going home, we quickly involve the right people to find solutions.

What We're Doing to Support Safe and Timely Discharges

We've put several key steps in place to improve how patients are assessed, supported, and discharged:

- **Early Assessment Within 72 Hours**
  Every patient receives a thorough assessment within the first three days to help guide their care and plan for a safe discharge.
- **Team-Based Care Planning**
  Hospital staff, community services, and crisis teams work together through regular ward rounds to review patient progress and next steps.
- **Keeping Track of Progress in Real Time**
  We use a simple "Red to Green" system to see what's helping patients move forward—and what's not. This helps us take action quickly to prevent delays.
- **Clear, Nationally-Recognised Discharge Pathways**
  We follow national guidelines to make sure every patient has a clear and appropriate route home or to ongoing care.
- **Spotting and Solving Barriers Early**
  At 72 hours, we use a Barriers Discharge Tool to identify anything that might delay discharge - so we can sort it out early and avoid unnecessary waiting.

Designing a Model to support Patient Flow (cont'd)

Early Signs of Progress

Since making these changes, we've already seen some positive results:

- **Stronger Teamwork Across Services**
  Different healthcare teams are now working more closely together.
- **Better and More Consistent Discharge Planning**
  Discharge plans are being made earlier and followed more reliably.
- **Greater Awareness of Delays in the System**
  We can now spot and address system-wide issues more quickly.

Our Guiding Principles

- **Easy-to-Follow Standards**
  We use simple, clear approaches that have been created together with staff and partners.
- **Everyone Working Together**
  All professionals are on board and using the same process.
- **Clear Responsibility**
  Everyone knows what they need to do and who is responsible for each step.

Listening and Learning

We ask patients and staff for feedback to help us improve. For example:

•Do you feel involved in planning your discharge?
•Do you know how long you'll be in hospital?

Their answers help us make care better.

So far since April 2025, we have already seen that patients are spending less time in hospital by reducing the average length of stay, to ensure this aligns with the national average length of stay. We monitor patient satisfaction as well as readmission rates.

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Progress and Next Steps

Rehabilitation Service

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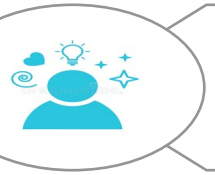
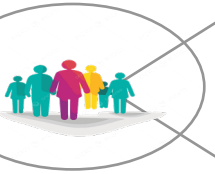
Mental Health Rehabilitation Services

The Mental Health Rehabilitation service was developed in 2022 as part of the Community Mental Health Transformation but also forms an integral element of the Inpatient Quality Transformation Programme. The service was co-designed to support individuals with complex mental health and social care needs and will support inpatient services:

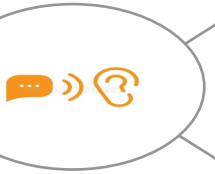


To reduce Out of area referrals and admissions to Out of Area Rehabilitation hospitals, support discharge from acute inpatient care and co-ordinate timely repatriation of individuals back into their local communities.

Improve local Rehabilitation provision to support people in their local communities and support people in supported housing and independent settings.



Inclusive and assertive community engagement to support people to maintain their independence and occupations.



To recruit and train a workforce that is highly skilled, who deliver evidence-based interventions, support and care that is recovery focused and reduces health inequalities. To enable a positive culture within the workforce.

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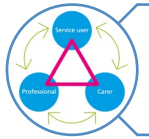
Core Features of the Service

Assessment and formulation of mental and physical health needs.

Co-ordination of care with an allocated worker.

Care delivery through a fully integrated stand-alone multi-disciplinary team, and the team will operate with a shared team caseload approach.

Co-produced, person-centred care planning – working towards personal recovery goals based on their skills, aspirations and motivations. Care plans completed with individuals and their carers/families, and reviewed regularly.



Carer engagement in all aspects of care in line with the Triangle of Care.

Specific ongoing assessment and intervention around co-existing problems, e.g. alcohol, substance misuse, depression, anxiety and physical health conditions.

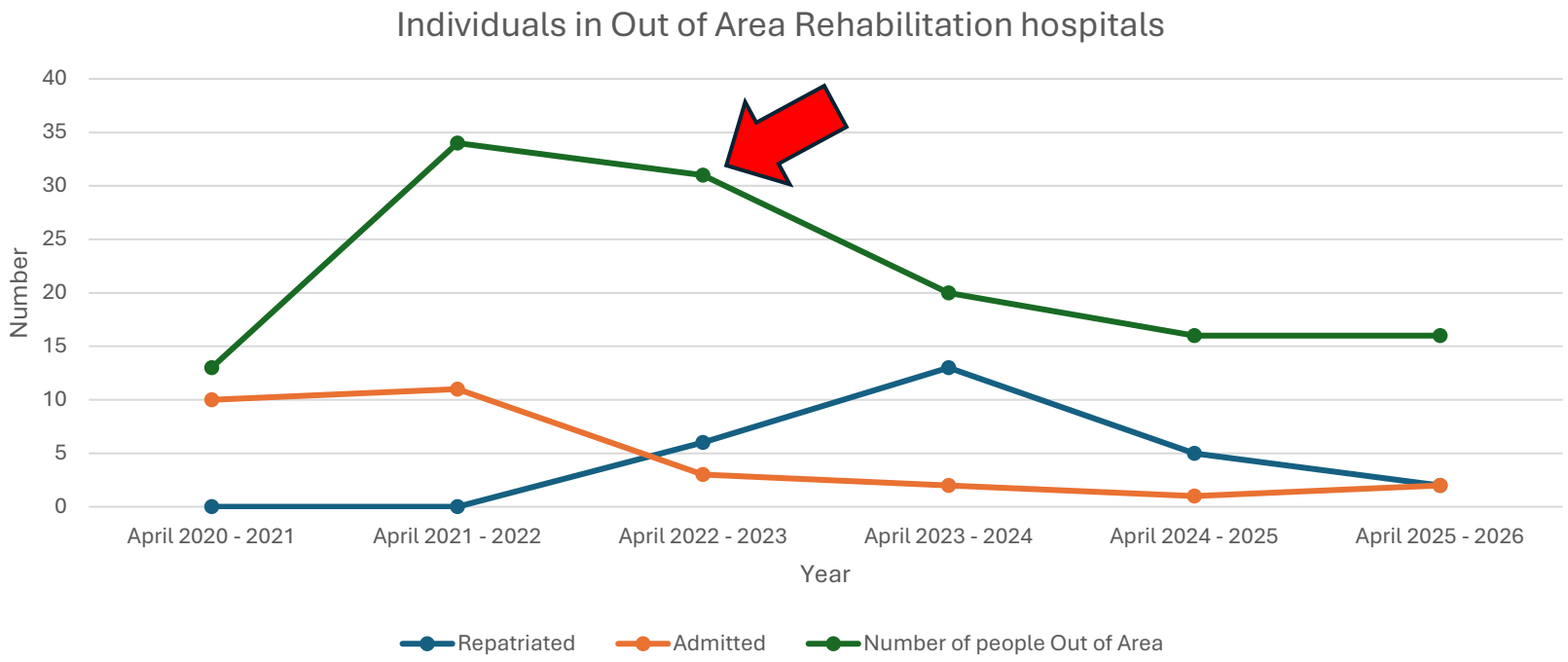
Risk management with a focus on positive risk taking.

An assertive approach to engagement to reduce the risk of service users' non-engagement.

All service users will be offered evidence-based psychological interventions.

Partnership working between Community Mental Health Rehab and external/third sector organisations to meet the psychosocial needs and co-morbidities of individuals.

Rehab Out of Area Position 2021/2022 – 2025/2026



This data shows that since 2022 (as indicated by the red arrow) when Shropshire Care Group initiated its ambitions for MH Rehabilitation and implemented a small Rehab service there have been:

- An increase in individuals being repatriated compared to previous years.
- A reduction in those being placed out of area and therefore being kept in their local communities.
- A reduction from 34 to16 individuals placed out of area and who are now living in their local communities.

	April 22-23	April 23-24	April 24-25	Totals:	2021/22 Comparison
Repatriated	6	13	5	24	2021 – 0 2022 - 4
Admitted	3	2	1	6	2021 – 10 2022 - 11
OOA Requests Received	11	3	2	16	
OOA Requests Declined	8	1	2	11	

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Achievements So Far

- **Significant reduction in the number of individuals placed Out of Area –** This is due to better integration between health and social care and voluntary sector partners to allow for a more resilient system.
- **Significant reduction in the number of referrals to Out of Area Rehab hospitals** – This has been due to clearer process for making requests and ensuring requests are appropriate/proportionate, supportive advice to clinical teams of less restrictive/alternative options, This has led to a **change of culture** around MH Rehabilitation and keeping care closer to home.
- More **robust multi-agency working** across MPFT, Local Authorities & ICB to support repatriation.
- Greater **scrutiny of care delivery by Out of Area providers**, through the recruitment of Patient Flow Manager, and greater focus on **discharge planning as early as possible.**
- Reduced length of stay in Out of Area High Dependency Rehab placements for those admitted since Community Mental Health Rehab development.

Service User Feedback

"I have had a schizophrenia relapse along with major depression. I lived at home with my mum as a recluse. Since coming here (The Elms) *I felt I have a future. This is because of staff, my meds and activities"*

"My journey has been stressful. Having to settle down plus all the moving I have had to do to and from different hospitals. I feel comfortable at Elms because I've been here a long time"

"I've found services with Rehab to be good. I want to give Rehab a star as they've been really supportive and non-toxic"

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Next Steps for Year Two

Housing and Supported Living Strategy

Continued development and piloting of operational processes and focus on / review of quality

Continue to build relationships for partnership working

Further Development = Phase 3 and Recruitment of workforce

IQTP: Hospital Avoidance; Reduced length of stay; Reduce dependence on Out of Area High Dependency Rehab (OOA HDR) beds.

Link into relevant service user related forums – establish our own service user and carer forum in the longer term

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Progress and Next Steps

Learning Disability & Autism

Mental Health Inpatient Quality Transformation
Learning Disability and Autism

People with a Learning Disability and Autistic people have needs related to their mental health like anyone else, but research tells us they are more likely to experience mental health challenges during their lifetime.

As a result, it is crucial Autistic people and people with a Learning Disability, who may experience inpatient Mental Health services are included and involved in any Inpatient Quality Transformation.

Everyone's needs and experience of Mental Health Inpatient services are unique; when inpatient care is provided for autistic people and those with a learning disability, it must be person centred in design, with appropriate reasonable adjustments where required and achievable within the service.

Localising and Realigning Care Learning Disability and Autism

Achievements and Progress to Date

- Delivered on the 'Provision of service to LD&A Service Users on Adult Mental Health wards – Baseline audit' in May 2024.
- Deep dive undertaken to understand patient journey, via anonymised case studies, linking in with the completed audit.
- Report produced by MPFT's Clinical Audit Team following data analysis – the report included an action plan.
- Learning Disability & Autism Awareness training is now being provided to all new staff during induction, including awareness of the LD&A Transforming care agenda - the Dynamic Support Register (DSR) and Care and Treatment Review (CTR) process etc.
- Within the Inpatient Service we have an Acute Liaison Nurse for people with Learning Disabilities and a Mental Health Liaison for Autistic Adults.
- These professionals provide support and advice from a Learning Disability and Autism perspective, related to reasonable adjustments and advice that can enhance a person's support during their inpatient journey.
- Development of sensory room and sensory pod (as shown in slide 39 below).

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Localising and Realigning Care Learning Disability and Autism

Achievements and Progress to Date

- Increased awareness of people who may have been accessing mental health services for some time, potential Autism needs are now being identified and considered.
- More availability of fidget items/sensory items/ board games on the wards and recently Lego.
- Sensory preferences are increasingly taken into consideration with inpatient staff sourcing relevant sensory equipment if required and helpful.
- There is increased understanding of sensory needs related to reduced lighting/drawn curtains in bedrooms.
- Food and dietary needs considered on the ward and addressed (which can be related to sensory needs) including specific orders from the kitchen / own items of food / graze boxes etc.
- Autistic people are given rooms further away from the central atriums where possible, with awareness of the sensory benefits.

Localising and Realigning Care
Learning Disability and Autism cont'd

Achievements and Progress to Date

- Increased understanding of the need for natural light / garden use and movement to assist recovery and regulation for autistic people, examples:
  - Regularity of support to walk in grounds
  - Yoga including for specific individuals on the ward
  - Availability and use of gym sessions
  - Tennis in the community during admission
- Increased presence of SaLT (Speech and Language Therapists) and the completion of communication assessments.
- The Mental Health Liaison for Autistic Adults is proactively being contacted by Occupational Therapists (re Sensory Screening/Work) and Speech and Language Therapists (re communication screening & advice).

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Localising and Realigning Care
Learning Disability and Autism cont'd

Achievements and Progress to Date cont'd

- Increased awareness of how physical health needs can impact on peoples' presentation, and fewer assumptions that changes in presentation are due to someone's Learning Disability or Autism diagnosis.
- Easy read information is more readily available and offered by ward staff.
- MDT working continues to improve, good representation at meetings.
- Board games/art activities with Activity Coordinators have provided structure to time in central atriums, encourages social interaction and participation in communal areas rather than isolation in bedroom areas.

Next Steps

- To continue focussing upon creating more accessible, efficient and recovery-oriented systems, ensuring patients receive high-quality, timely, and appropriate inpatient care.
- To continue improving the ward environment for people with a Learning Disability and Autistic people whilst providing individual person-centred interventions.
- To develop services that are co-designed by people with Lived Experience and their families to help influence best practice and support better outcomes whilst ensuring diverse needs are met, services are coordinated and inequalities addressed.
- To focus on closer partnership working for discharge, involving Inpatient Services, Community Learning Disability Teams, Local Authorities and the Transforming Care Team. This is crucial for providing comprehensive, effective, and person-centred care and support leading to timely discharge avoiding unnecessarily extended lengths of stay.

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Progress and Next Steps

Culture of Care

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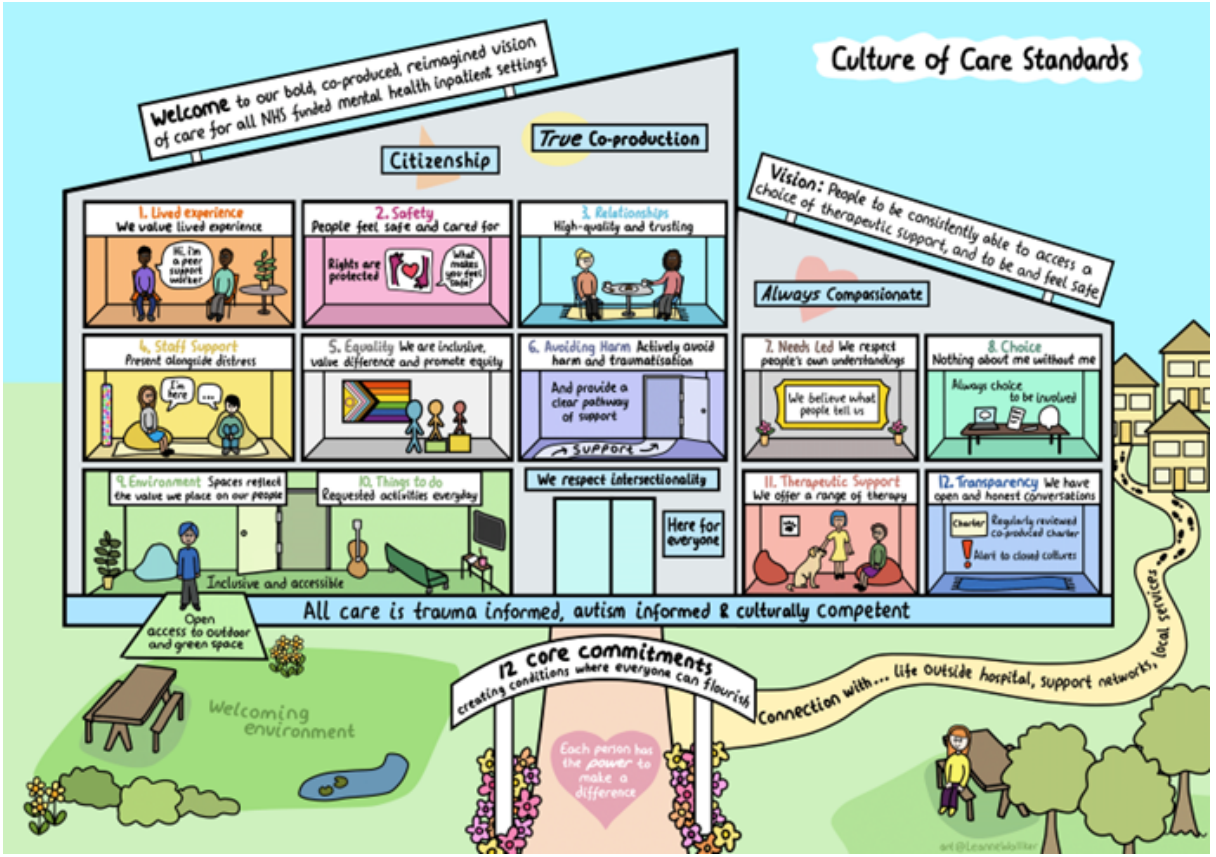
Culture of Care

Launched in January 2024 and running until March 2026, Culture of Care supports around 60 providers to embed 12 co-produced core commitments, from valuing lived experience to promoting trauma-informed, autism-aware, and culturally competent care.

Key strands include quality-improvement coaching, the Staff Care and Development programme, and ward-to-board leadership development, all delivered alongside people with lived experience.

Through reflective practice, coaching, and co-production with patients, the programme aims to enhance patient experience, reduce restrictive interventions, and improve staff well-being and retention.

This programme aims to improve the culture of inpatient mental health, learning disability and autism wards for patients and staff so that they are safe, therapeutic and equitable places to be cared for, and fulfilling places to work.



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What is Culture of Care?

The Culture of Care Standards, launched in 2023, set out **12 key principles** for high-quality, patient-centred mental health inpatient care in the UK. These standards focus on creating a safe, therapeutic, and empowering environment for patients, with an emphasis on:

Our First Completed Improvement - Pine Ward (Acute Adult Psychiatric Inpatient Ward at the Redwoods Centre)

Book Club

The idea was to establish a mobile book club for patients across Pine Ward which would eventually be shared across the Trust. The aim was to provide a meaningful and self-initiated activity that encouraged reading, social interaction, and community engagement. It served as a tool to combat isolation, promote communication with staff and peers, and inspire a reading culture among patients.

Since its introduction, the initiative has already seen 30 patients participate by borrowing books, highlighting its early success in creating communal and therapeutic engagement.

- Provided reading materials at different levels (e.g. easy-read, picture books).
- Chose appropriate books with consideration for patient needs, such as font size.
- Actively sought feedback from patients on reading materials.
- Inspired people to read.
- Good conversation prompter – encouraged social interaction and communication with staff and other patients.
- Combating isolation on ward.
- Engaging with patients to encourage a sense of community.

Further guiding principles that the book club will encompass are:

- **Trauma informed:** facilitating open conversations/e.g. books on speaking out, books of personal account/lived experience books and encouraging choice of what to read.
- **Autism informed:** consistent group can provide structure, delicate way of encouraging community and helping people to avoid isolation, providing books around people's special interests, support with social skills - starting/getting involved in the group.
- **Anti-racist:** supplying books around different cultures/ places/religions etc.

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Other ideas being worked on Pine Ward:

- **Welcome Pack Photobook:** A patient passionate about photography collaborated on updating the Welcome Pack Photobook by capturing images of the hospital grounds and is excited to be credited and involved in future projects, with the next step being the creation and approval of the photobooks.
- **Increase access to more training and ward champions:** To improve staff knowledge and ultimately provide a better service.
- **Moving the television:** Relocating the television from the TV Lounge into a more central ward area and to a more functional, comfortable, inclusive and accessible communal space to encourage patients to spend more time in shared areas and promote greater social engagement.
- **Ward Reviews**: We propose updating ward reviews to consistently include trauma-informed care. Improving the effectiveness of multidisciplinary teams (MDTs) through clearer communication and collaboration will enhance care planning and consistency. Additionally, setting and clearly communicating regular review times responds directly to repeated patient requests for more predictable and transparent care.
- **Redesign of MDT/Family Room**: In collaboration with service users, families, and carers, we aim to redesign the MDT/Family Room to better meet their needs. Key concerns include the current room size being inadequate, previous incidents of aggression occurring in the space, and the difficulty of accommodating all family members comfortably during meetings.
- **Recruiting Peer Support Workers:** Recruiting more peer support workers enhances mental health care by offering empathetic, experience-based support that builds trust, improves recovery outcomes, and eases pressure on clinical staff, making services more effective and accessible.

Ideas being worked on Yew Ward:

- **MDT Environment**: We are improving the environment so that the team and the service users can enjoy the space together. We have put a round table rather than a desk as it creates a more welcoming space for open and respectful discussions.
- **Activities:** We offer culturally inclusive activities along with mindfulness and breathing exercises to promote stress relief and provide practical skills for everyday life.
- **Pet Therapy**: We are exploring pet therapy to support the service users by creating a more calming ward atmosphere and promote emotional wellbeing. This aligns with trauma informed principles by offering safe, non-verbal forms of comfort.
- **Trauma Informed Training**: Trauma-informed training supports service users by fostering a care environment that acknowledges the widespread impact of trauma, actively works to prevent re-traumatisation, and equips staff with the empathy, consistency, and emotional awareness needed to help individuals feel safe, understood, and respected ultimately building trust, strengthening relationships, and empowering service users through care plans tailored to their emotional, psychological, and cultural needs.
- **Yew Ward Garden Improvements:** Enhancing the Yew Ward garden is essential to fostering a therapeutic and inclusive environment. A safe outdoor space can reduce agitation, support emotional regulation, and boost mental wellbeing, while also providing opportunities for activities like gardening, mindfulness, and cultural events that enrich the ward's therapeutic culture.

Sensory Room

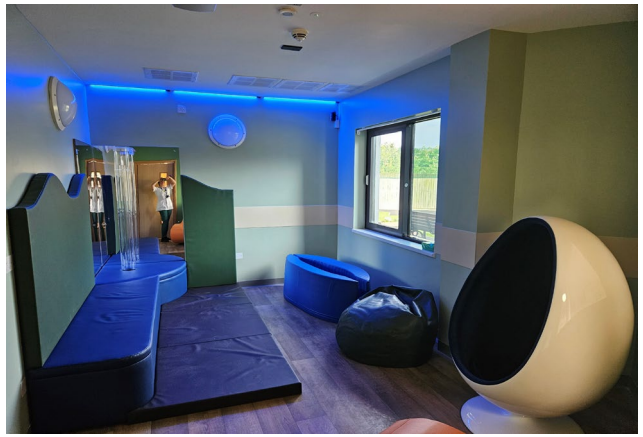
A longstanding lived experience rep in Shropshire Telford & Wrekin (STW) has been advocating within Mental Health and Autism services for the inclusion of a sensory room in our inpatient services, to ensure we have a neurodiverse friendly environment that fulfils the sensory needs of the people using our wards.

This lived experience led service improvement has been operationalised by the Clinical Lead Occupational Therapist (OT) for STW acute inpatient wards and spread through sensory trolleys to ensure equity across the wards.

Pine Ward used the opportunity of being a Culture of Care Pilot Ward to introduce their sensory trolley using a Quality Improvement (QI) approach and Culture of Care principles.

Helps people feel relaxed and calm.

Enjoy the fidget items and weighted blankets.



The projected images along with calming music is nice to have on the ward

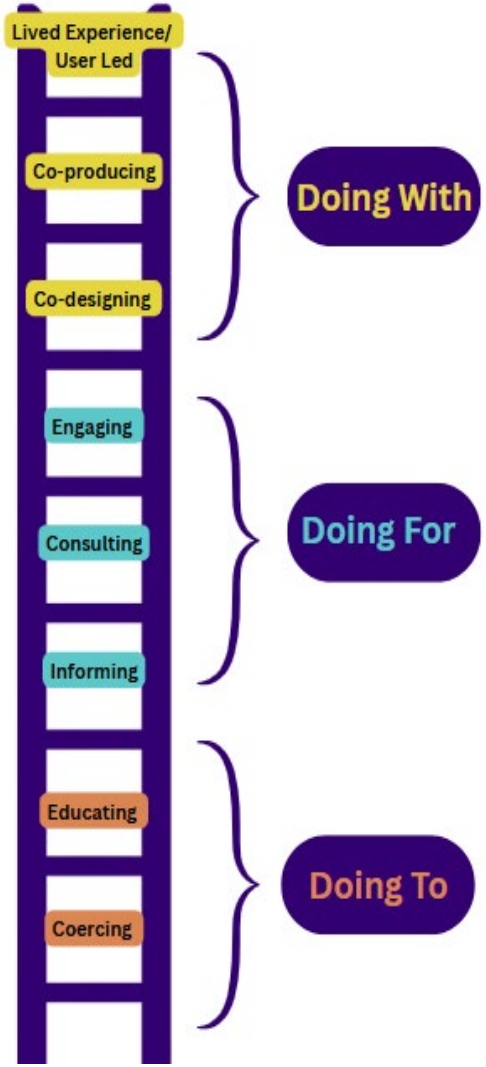
- This project has had varying levels of co-production that have shifted throughout the development where we have spent time reflecting on how we could have been more consistent in this.
- The evaluation of this project will give us opportunity to consider the co-production of the project and patient feedback formally.

Co-production of IQTP so far...

- From the start of IQTP, Shropshire, Telford and Wrekin (STW) have involved their Professional Lead for Lived Experience Practice who holds their own mental health experiences and those of people around them.
- The role has acted as a link to the trust wide Co-Production and Involvement team. This role has led to the soon expansion of our peer support workforce into inpatients.
- Our Senior Peer Co-Production and Involvement Facilitator has been involved in the Culture of Care pilot ward. Our Allied Health Profession (AHP) assistant has continued to actively use the community meetings and other forms of communication to involve and consult with people on our wards and their loved ones.
- We refer to the co-production ladder and our lived experience staff members have acted as critical friends to question what are we doing? What do we need to do? What power are we sharing or need to share?

The intention....

- *To aim for true* co-production throughout the programme. Co-production is what will make this transformational for the people who use inpatient services, their loved ones and unlock the true potential of the transformation and the recovery of the people using our services.
- The group have been working alongside lived experience staff, ensuring we do the foundational work that makes us ready to being accountable to *true* co-production by ensuring it is safe, supportive as well as equal and accessible to those we wish to co-produce with.



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Co-Production & Involvement

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The Challenges...

- It takes time to push all cultures to readiness, and ensure safety, support and accessibility is in place for Lived Experience Representatives. It also takes paid lived experience roles with the right expertise and focus of role.

- It also takes patience and transparency to ensure we don't use co-production as a buzz word, instead being honest about the consultation and involvement we have started to do with our communities and the foundations we have made to co-produce going forward.

The Way Forward...

- In the process of recruiting a Lived Experience Representative to be a member of the system wide STW IQTP steering group.

- Set up an accessible Lived Experience Advisory Group (LEAG) to sit alongside and feed into the STW IQTP steering group.

- We have a matched Band 6 Advanced Lived Experience Practitioner (co-production specialism) currently going through vacancy control. If this role is accepted, it will be a Trust Wide role focused on the co-production of the IQTP, which will have the time and expertise to push us forward much quicker into Year 2.

- STW System Wide comms and engagement task and finish group with membership from co-production colleagues so efforts to co-produce are coordinated.

- Peer Support Pilot roles are due to go out to advert imminently. STWs Professional Lead for Lived Experience Practice will focus efforts on recruiting, embedding and evaluating this work.

Communications and Engagement

NHS Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin has launched the next phase of communications and engagement activity to support the development of the three-year Mental Health Inpatient Quality Transformation Strategy.

Aims and Objectives

The core aims of this engagement activity are to:

- Ensure the voices of those with lived experience are central to the development of the strategy, including service users, carers, staff, and professionals.
- Understand people's experiences of accessing and using local mental health services.
- Gather views on how the current model of care could be enhanced - focusing on delivering care closer to home where possible, and designing future services that are bold, aspirational, and visionary.
- Identify barriers to access, any potential positive or negative impacts of proposed changes, and how we can best support people (including travel support) if changes are implemented.

Approach

The engagement activity builds on earlier involvement and aims to provide meaningful opportunities for all stakeholders to help shape future service models. We are delivering a 12-week engagement period over summer 2025, combining digital and face-to-face methods to maximise accessibility and inclusivity.

Our approach includes:

- **Online and paper-based surveys** for service users, carers, professionals, and the wider public.
- **Listening events and stakeholder workshops**, including sessions for VCSE, community groups, and clinical teams.
- **Focus groups and one-to-one interviews**, particularly targeting seldom-heard groups, in collaboration with Healthwatch and voluntary sector partners.
- **Opportunities for feedback through existing forums and networks**, as well as hyper-local conversations to ensure broad community reach.

This plan reflects our continued commitment to open, transparent dialogue and ensures we hear from a wide range of voices across Shropshire, Telford and Wrekin.

Next steps

- The 12-week engagement period commences 5th August 2025. Feedback gathered will be carefully analysed following the conclusion of the engagement phase. The insights will directly inform the shaping of the strategy and future delivery plans for mental health inpatient services across the system.
- We will provide updates to stakeholders throughout the process and will work closely with NHSE, local authorities, and scrutiny bodies as this work progresses.

Communication and Engagement Plan

- This Communications and Involvement Plan was developed before the announcement of the General Election in July 2024. As a result, planned involvement activities were paused. The strategy was created using insights from earlier engagement, but it was recognised that further engagement would be necessary later in 2024/2025.
- The intention is to conduct retrospective involvement now the strategy has been submitted to NHSE and during the development of delivery plans. This activity will take place between August and November 2025.

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Summary

Thank you for taking the time to read our review. We hope this has given you, the reader, a sense of the work we have all undertaken so far and set out our ambition and vision for the future.

We wish to sincerely thank all our contributors, to this review, and for their hard work to date.

We warmly welcome feedback and input into our Transformation Programme.